

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32883
State File No. 8360
Registrar's No.

FILED SEP 25 1952

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived.) If institution: residence before admission. a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) 4679 Tesson	
3. NAME OF DECEASED (Type or Print)	a. (First) Julia	b. (Middle) E	c. (Last) Dilg
4. DATE OF DEATH	Sept. 2, 1952		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Sept. 7, 1882
9. AGE (In years last birthday) 69		10. DATE OF BIRTH Sept. 7, 1882	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Valentine Meyer		13b. MOTHER'S MAIDEN NAME Margaret Moser	
14. NAME OF HUSBAND OR WIFE Peter Dilg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Elsie Dilg		ADDRESS 4679 Tesson	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis & Pericarditis</u> DUE TO (c) <u>Coronary insufficiency</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200	
22. I hereby certify that I attended the deceased from Aug 1952 to Sept 2, 1952, that I last saw the deceased alive on Sept 2, 1952, and that death occurred at 12:35 PM, from the causes and on the date stated above.			
23. SIGNATURE <u>Dr. J. M. O'Neil</u>		23b. ADDRESS 5209 S. Hanover	
23c. DATE SIGNED 9-7-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/5/52	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
24d. LOCATION (City, town, or county) (State) St Louis County Mo.			
DATE REC'D BY LOCAL REG. SEP 4 1952		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons 7027 Gravois	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

B. P. Kidwell

Licensed Embalmer No. *3877*

P. O. Address *7027 Gravaich*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.